State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

April 11, 2005

MMCD All-Plan Letter 05004

TO: County Organized Health Systems (COHS) Plans
Geographic Managed Care (GMC) Plans
Prepaid Health Plans (PHP)
Primary Care Case Management (PCCM) Plans
Two-Plan Model Plans

SUBJECT: PERSONAL INJURY INQUIRY LETTER

As discussed recently at the All Plan Quarterly Meeting in January 2005, the Department of Health Services (Department) intends to increase compliance with Personal Injury (PI) reporting by sending the PI inquiry letter to the Medi-Cal Managed Care population. In order for the Department to achieve its recovery goals, cooperation and coordination will be necessary with our managed care plan partners.

The PI Unit is responsible for the identification and recovery of Medi-Cal funds that were expended on behalf of Medi-Cal beneficiaries involved in personal injury actions. The PI Unit asserts liens against any settlement, judgment or award received by a beneficiary for the cost of injury related services paid by Medi-Cal. Attorneys, insurance companies and beneficiaries provide the primary sources of case referrals for the PI Unit. Fee for Service (FFS) beneficiaries and members of the older County Organized Health Systems (COHS) Plans receive a PI inquiry letter that is generated automatically whenever a claim is paid that includes trauma codes. This program generates the PI inquiry letter to San Mateo and Santa Barbara COHS plan members based on trauma codes reported from monthly encounter data.

A PI case is established when the PI Unit receives a referral on a Medi-Cal beneficiary and eligibility is confirmed. Medi-Cal payment history is then ordered for the period of time from the date of injury to the present. The PI Unit staff reviews the beneficiary's payment data, develops an itemization of payments containing injury-related services, and asserts a Medi-Cal lien against any settlement, judgment, or award for the itemized claim amount. These settlements, judgments, or awards facilitate collection for the Recovery Section of nearly $40 million per year. For managed care beneficiaries, the PI Unit must order the payment history from the Medi-Cal managed care plans. Your timely response and cooperation in providing service information for your members is greatly appreciated. Per your contract, it is the responsibility of the managed care plans

to provide the requested information within 30 days of the request. It is anticipated that the volume of such requests will increase with the mail out of the PI inquiry letter. In an effort to increase PI case referrals, programming has been developed to initiate the PI inquiry letter to the larger managed care population, including the Two-Plan Model and Geographic Managed Care (GMC) population using the same methodology that currently exists for the FFS population and COHS members. The PI inquiry letter will be automatically generated to managed care plan members based on encounter data that identifies trauma codes. The Third Party Liability Branch budget change proposal for 2005/2006 includes a significant increase in recoveries based upon the anticipated increase of PI case referrals from the managed care population.

Enclosed is a PI referral letter for your review and comment. The letters sent to beneficiaries include a self-addressed stamped envelope. The Department anticipates there will be minimal contact to the plans. The proposed timeline to initiate the PI letter to the remaining COHS population is April 2005, and July 2005, for the Two-Plan model and GMC members.

Please send any questions or comments within 30 days directly to:

Vivian Auble, Chief, Recovery Section
Third Party Liability Branch
Department of Health Services
1500 Capitol Avenue
P.O. Box 997425, MS 4720,
Sacramento, CA 95899-7425

Thank you for your cooperation with this effort.

Sincerely,

Vanessa M Baird

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Enclosure

cc: Vivian Auble, Chief, Recovery Section
Third Party Liability Branch
Payment Systems Division
1500 Capitol Avenue
P.O. Box 997425, MS 4720
Sacramento, CA 95899

State of California—Health and Human Services Agency

DEPARTMENT OF HEALTH SERVICES
THIRD PARTY LIABILITY/PERSONAL INJURY UNIT
P. O. BOX 997425
SACRAMENTO, CA 95899-7425

THIS IS NOT A BILL, this is a questionnaire being sent to you by Medi-Cal.

SIDE A

Records show that **Medi-Cal has paid** for services for the above illness/injury on or about _____.
If an illness or injury is caused by another person or persons, someone else may be responsible for paying for treatment. As part of our effort to reduce Medi-Cal costs, we request that you answer the following questions.

If you have filed or will be filing a claim with an insurance company, a lawsuit with or without an attorney, or receive money for an injury or illness, state law requires that you or your representative notify the above Medi-Cal office.

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Do you think someone else was responsible for your illness/injury? ☐ Yes ☐ No
2. Is there any insurance (other than Medi-Cal/Medicare) covering you or anyone else for this illness/injury? ☐ Yes ☐ No
3. Do you plan to pursue a settlement in this matter? ☐ Yes ☐ No
4. Have you hired an attorney? ☐ Yes ☐ No
5. Have you received a settlement (money or judgment) as a result of this illness/injury? ☐ Yes ☐ No

***STOP.* READ THE FOLLOWING INSTRUCTIONS CAREFULLY.**

If you have answered **YES to ANY** of the above questions, **COMPLETE SIDE B** and return this letter using the enclosed postage-paid envelope.

If you have answered **NO to ALL** of the questions, disregard this letter—**DO NOT RETURN**.

Information about any claim or legal action you may take is requested by authority of the Welfare and Institutions Code, Sections 10020, 10022, 10024, 14000, 14023, 14024, 14124.70 through 14124.79, and Title 22, California Administrative Code, Section 50771. We use your Social Security number provided under the Title 22 California Administrative Code Section 50187 and other information for contacting insurance companies, providers of health care, county agencies, or your attorney. The information obtained is also used to seek collections from insurance companies or other sources.

PART 1. INJURED PERSON

1. Name of injured person
2. Date of birth (Month/Day/Year) ____/____/____
3. Social Security number ____-____-____

Address (number, street) City ZIP code

4. Medi-Cal number
5. Date of injury (Month/Day/Year) ____/____/____

Telephone number
Work ( ) Home ( )

6. What type of accident did you have?
☐ Auto ☐ Slip and Fall ☐ Malpractice ☐ Other

7. Briefly describe your injury

8. If you were in an auto accident, do you have auto insurance coverage? ☐ Yes ☐ No If yes, complete items 9 through 14.

9. Name of your insurance company and agent

Address City ZIP code

Telephone number
( )

10. Name of policyholder
11. Policy or claim number
12. Have you received a settlement? ☐ Yes ☐ No
13. If yes, when? (Month/Day/Year) ____/____/____
14. If yes, how much money did you receive?
$

Were any other Medi-Cal recipients injured in this accident? ☐ Yes ☐ No **If yes, complete the following.**

15. Name

Address (number, street) City ZIP code

16. Date of birth (Month/Day/Year) ____/____/____
17. Social Security number ____-____-____
18. Telephone number
( )
19. Medi-Cal number

PART 2. DID ANOTHER PERSON CAUSE THIS INJURY? ☐ Yes ☐ No If yes, complete the following.

20. Name of person who caused this injury
21. Do they have insurance coverage? ☐ Yes ☐ No If yes, complete items 22 through 27.

22. Name of insurance company and agent

Address (number, street) City ZIP code

Telephone number
( )

23. Policy or claim number
24. Name of policyholder
25. Have you received a settlement? ☐ Yes ☐ No
26. If yes, when? (Month/Day/Ye ____/____/____
27. If yes, how much money did you receive?
$

PART 3. DO YOU HAVE AN ATTORNEY FOR THIS INJURY? ☐ Yes ☐ No If yes, complete the following.

28. Name of attorney

Address (number, street) City ZIP code

Telephone number
( )

29. Have you received a settlement? ☐ Yes ☐ No
30. If yes, when? (Month/Day/Year) ____/____/____
31. If yes, how much money did you receive?
$
32. Civil Complaint number County filed

PART 4. WAS YOUR INJURY CAUSED BY YOUR JOB? ☐ Yes ☐ No If yes, complete the following.

33. Name of Employer

Address City ZIP code

Telephone number
( )

34. Name of employer's insurance company

Address City ZIP code

Telephone number
( )

35. Is a Worker's Compensation action going on now?
☐ Yes ☐ No
36. If yes, write WCAB case number here
37. Insurance claim number

STATE LAW REQUIRES THAT THE MEDI-CAL PROGRAM BE REPAID IF ANY JUDGMENT, AWARD, OR SETTLEMENT IS RECEIVED FOR THIS INJURY.

38. Comments

39. Name of injured minor or person unable to complete this form.
40. Your relationship to injured person.
41. Signature of person completing this form.
X
42. Your phone number
( )
Date

RETURN THIS LETTER USING THE ENCLOSED POSTAGE PAID ENVELOPE